STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

OF

VOLUNTEER STATE HEALTH PLAN, INC.
d\b\a BlueCare and
d\b\a TennCare Select

CHATTANOOGA, TENNESSEE

FOR THE PERIOD JANUARY 1, 2002,
THROUGH DECEMBER 31, 2002

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DATE: December 10, 2003

A Limited Scope Financial and Compliance Examination and Claims Processing Market Conduct Examination of Volunteer State Health Plan, Inc., Chattanooga, Tennessee, was completed June 13, 2003. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a market conduct examination "by test" of the claims processing system of Volunteer State Health Plan, Inc. (VSHP).

Further, this report reflects the results of a limited scope examination of the reported VSHP financial statement selected account balances. This report also reflects the results of a compliance examination of VSHP's policies and procedures regarding statutory and contractual requirements.

A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of VSHP was conducted jointly by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of section 3-6. of the Contractor Risk Agreement between the State of Tennessee and VSHP (Contractor Risk Agreement), section 2-15 of the Agreement for the Administration of TennCare Select between the State of Tennessee and VSHP (Administrative Service Agreement), Executive Order No. 1 dated January 26, 1995, and § 56-32-215 of the Tennessee Code Annotated (Tenn. Code Ann.).

VSHP is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of VSHP for its TennCare lines of business. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

The limited scope financial examination focused on selected balance sheet accounts and the TennCare income statements as reported by VSHP on its National Association of Insurance Commissioners (NAIC) Annual Statement for the year ended December 31, 2002, the Medical Loss Ratio Report filed by VSHP as of December 31, 2002, the Medical Fund Target Reports filed by VSHP as of December 31, 2002, and a review of the calculations supporting the risk banding option for the period ended June 30, 2002.

The limited scope compliance examination focused on the review of VSHP's provider appeals procedures, provider agreements and subcontracts; the demonstration of compliance with Federal Title VI of the 1964 Civil Rights Act and the Insurance Holding Company Act.

The fieldwork was performed from March 10 through March 12, 2003, and June 2 through June 13, 2003.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that VSHP's TennCare operations were administered in accordance with the Contractor Risk Agreement, the Administrative Services Agreement and state statutes and regulations concerning HMO operations. The examination also provided reasonable assurance that VSHP TennCare enrollees received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether VSHP met its contractual obligations under the Contractor Risk Agreement and the Administrative Services Agreement and whether VSHP was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 *et seq*.;

- Determine whether VSHP had sufficient financial capital and adequate risk reserves to ensure the uninterrupted delivery of health care services for its TennCare members on an ongoing basis;

- Determine whether VSHP properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether VSHP had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and

- Determine whether VSHP had corrected deficiencies outlined in prior reviews of VSHP conducted by the Comptroller or examinations conducted by TDCI.

III. PROFILE

A. Administrative Organization of VSHP

Volunteer State Health Plan II, Inc. (VSHP II), a wholly-owned subsidiary of Blue Cross Blue Shield of Tennessee, Inc. (BCBST), was chartered as a for-profit corporation in the State of Tennessee on July 1, 1996, for the purpose of providing managed health care services to individuals participating in the State's TennCare Program in all community service areas except the Knox County and East Tennessee community service areas. On November 8, 1996, by way of the Articles of Amendment to the Charter, VSHP II changed its name to Volunteer State Health Plan, Inc.

On January 1, 1998, VSHP merged with Volunteer State Health Plan-Eastern Tennessee, Inc., (VSHP-ET), a not-for-profit corporation also wholly-owned by BCBST. VSHP-ET was a licensed HMO that participated in the TennCare Program in the Knox County and East Tennessee Community Service Areas. VSHP was the surviving corporation after the merger was completed. After the merger of VSHP and VSHP-ET, VSHP provided coverage to TennCare enrollees on a statewide basis.

The officers and board of directors for VSHP at December 31, 2002, were as follows:

Officers for VSHP

Mark Edward Austin, President & CEO
David Lee Deal, Treasurer
John Linville Shull, Secretary
Harold Hoke Cantrell, Assistant Treasurer
Shelia Dian Clemons, Assistant Secretary

Board of Directors for VSHP

Thomas Kinser
Vicky Brown Gregg
Mark Edward Austin
Jerry Lewis Juneau
Joan Carol Harp

B. Brief Overview

Effective November 4, 1996, TDCI granted VSHP II (later VSHP) a certificate of authority to operate as a TennCare HMO. Thereafter, VSHP began operating as a

statewide MCO in the TennCare program. VSHP operated this line of business under the plan name BlueCare.

Effective July 1, 2001, VSHP's contract with the TennCare Bureau limited BlueCare enrollment to the Eastern Grand Region. Also effective July 1, 2001, through TennCare Select, a separate line of business, VSHP entered into the Administrative Services Agreement with the TennCare Bureau to administer a safety net plan. Under this agreement, the state, and not VSHP d/b/a TennCare Select, is at-risk for the cost of medical services versus VSHP d/b/a TennCare Select. TennCare Select provides services for children in state custody or at risk of being placed in state custody; children that are Social Security Income eligible; children receiving services in an institution or under the State's Home and Community Based Service waiver; and TennCare enrollees residing out-of-state. Furthermore, TennCare Select has received additional enrollment from MCOs with terminated TennCare contracts. These enrollees remain in TennCare Select until the Bureau of TennCare determines if the remaining contracted TennCare MCOs are able to accept additional enrollees.

BlueCare's enrollment as of June 30, 2001, was 607,489. As of July 31, 2001, BlueCare's enrollment was reduced to 275,077 as a result of the reduction in service area. TennCare Select's enrollment on July 31, 2001 was 87,992.

Effective July 1, 2002, the Contractor Risk Agreement with BlueCare was amended to temporarily operate under a non-risk agreement from July 1, 2002, through December 31, 2003. This period, otherwise known as the "stabilization period," was established to allow all MCOs a satisfactory period of time to establish financial stability, maintain continuity of a managed care environment for enrollees and assist the Bureau of TennCare in restructuring the program design to better serve Tennesseans adequately and responsibly. BlueCare agreed to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures as they existed April 16, 2002.

VSHP's BlueCare plan is currently authorized by TDCI and the TennCare Bureau to participate in the TennCare program in the Eastern Grand Region. VSHP's TennCare Select program operates statewide.

VSHP derives the majority of its revenue from payments from the state for providing medical benefits to TennCare enrollees. As of December 31, 2002, VSHP reported 261,297 BlueCare members and 233,881 TennCare Select members.

C. Claims Processing Not Performed by VSHP

During the period under examination, VSHP subcontracted with the following vendors for the provision of specific TennCare benefits and the processing and payment of related claims submitted by providers:

- Advance PCS Health, L.P. (PCS**)** for pharmacy claims, and
- Doral Dental USA LLC (Doral) for dental services.

Effective October 1, 2002, TennCare assumed the responsibility for processing all dental claims under a single dental benefit manager. At that time, VSHP terminated its contract with Doral Dental. As of December 31, 2002, the only subcontractor who processed claims for VSHP was Advance PCS. Claims for pharmaceutical and dental services were not included in VSHP's pool of claims from which claims were selected for testing. Therefore, except for timeliness testing of pharmacy claims, no pharmacy or dental claims were tested as part of this examination.

IV. PREVIOUS EXAMINATION FINDINGS

A. TDCI Examination

The following were claims processing and internal control deficiencies cited in the examination by the Tennessee Department of Commerce and Insurance, TennCare Division, for the period January 1, 2000, through March 31, 2000:

1. VSHP did not process 100% of all claims within 60 days of receipt.
2. Two of 44 denied claims did not reflect all denial reasons.
3. The coinsurance or deductible was not properly calculated on three claims.
4. The data reported on 16 claims was not correctly entered into the claims processing system.
5. The Claims Status Report submitted to TennCare on a weekly basis was not prepared correctly.
6. Adequate documentation was not maintained for all provider complaints.
7. One of 10 provider complaints reviewed was not responded to in a timely manner.
8. Control of incoming claims was not established immediately in the mailroom.
9. Outstanding checks were incorrectly reported as a liability.
10. Claims Payable was significantly overstated.

The deficiency numbered above as 3 is repeated as part of this report.

B. Comptroller's Examination

The following were claims processing and internal control deficiencies cited in the examination by the Comptroller of the Treasury, Department of Audit, Division of State Audit, for the period January 1, 1996, through December 31, 1998:

1. Six claims were improperly denied.
2. One claim was processed under the wrong provider number.
3. One claim resulted in an incorrect payment as the result of an incorrect procedure code.
4. VSHP inadequately reported encounter data to the TennCare Bureau.
5. Co-payment and deductibles were not always properly calculated

The deficiency numbered above as 5 is repeated as part of this report.

V. SUMMARY OF PERTINENT FACTUAL FINDINGS

A. Summary of Deficiencies – Financial

No deficiencies were noted in the limited scope review of financial statement account balances.

B. Summary of Deficiencies – Claims Processing

1. For one of the 20 TennCare Select claims tested, a claim was processed using an incorrect price resulting in an incorrect payment.

2. For one of the 20 TennCare Select claims tested, the copayment was incorrectly applied.

C. Summary of Deficiencies - Other

1. A subcontract reviewed did not include all of the required Title VI language.

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, VSHP files annual and quarterly statements in accordance with NAIC and statutory guidelines with the Tennessee

Department of Commerce and Insurance. The department uses the information filed in these reports to determine if VSHP meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At December 31, 2002, VSHP reported $54,419,629 in admitted assets, $19,746,492 in liabilities and $34,673,137 in capital and surplus on its 1st amendment to the 2002 NAIC Annual Statement. VSHP reported total TennCare revenue of $290,620,958, investment income of $2,733,376, medical expenses of $283,587,061 and administrative expenses of $30,630,745. VSHP reported a net loss before income tax of $20,863,472 for the 12 months reported.

It should be noted that the premium revenue and medical expenses are correctly reported per statutory accounting principles for only the at-risk periods for only the BlueCare plan through June 30, 2002. As previously mentioned, BlueCare's Contractor Risk Agreement was amended July 1, 2002, to temporarily operate under a non-risk agreement.

1. Capital and Surplus

   Tenn. Code Ann. § 56-32-212(a)(2) requires VSHP to establish and maintain a minimum net worth equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150 million of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of $150 million for the prior calendar year.

   Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions pursuant to any other federal law adopted by amendment to the required Title XIX state plan." Based on this definition, all TennCare payments made to an HMO licensed in Tennessee are included in the calculation of net worth and deposit requirements.

   VSHP's premiums per documentation obtained from the TennCare Bureau totaled $1,106,532,272; therefore, the current minimum statutory net worth requirement is $20,347,984. VSHP reported a capital and surplus $14,325,153 in excess of the statutory requirement.

The following is a summary of VSHP's premium revenue as defined by Tenn. Code Ann. § 56-32-212(a)(2):

I. TennCare Select	Payments by the State
Administrative fee payments to TennCare Select For the period January 1 through December 31, 2002	$48,889,365.20
Reimbursement for medical payments to TennCare Select For the period January 1 through December 31, 2002	471,261,243.94
Reimbursement for premium tax payment to TennCare Select For the period January 1 through December 31, 2002	9,336,090.95
II. BlueCare	
Capitation payments to BlueCare during the risk period From January 1 through June 30, 2002	295,680,341.79
Administrative fee payments to BlueCare For the period July 1 through December 31, 2002	19,209,014.23
Reimbursement for medical payments to BlueCare For the period July 1 through December 31, 2002	259,915,038.14
Reimbursement for premium tax payments to Blue Care For the period July 1 through December 31, 2002	2,241,178.05
Total premium revenue	$1,106,532,272.30

2. Restricted Deposit

Tenn. Code Ann. § 56-32-212(b)(3) requires all HMOs licensed in the state to maintain a deposit equal to $100,000 for each $10 million or fraction thereof of annual premium revenue in excess of $20 million and less than $100 million as reported on the most recent annual financial statement filed with TDCI, plus $50,000 for each $10 million or fraction thereof of annual premium revenue in excess of $100 million.

VSHP's contractual deposit requirement at December 31, 2002, was $6,750,000. VSHP has provided TDCI with the necessary safekeeping receipt documenting that

deposits totaling $5,550,000 have been pledged for the protection of TennCare enrollees. Shortly after the completion of fieldwork, VSHP complied with the necessary statutory deposit requirement.

3. Management Fee

BCBST provides the administrative services for the BlueCare and TennCare Select plans. The fee paid to BCBST for administrative services is based on an approved management agreement by TDCI.

During the examination period January 1, 2002, through December 31, 2002, the TennCare Select line of business was paid a monthly fixed administrative fee by the TennCare Bureau in exchange for administrative services for the TennCare Select plan per section 4-1.1(d) of the Administrative Services Agreement. This fixed administrative fee equals the administrative fee paid to BCBST by TennCare Select.

As discussed below, BlueCare had selected risk banding option 3 as allowed in the Contractor Risk Agreement for the period January 1, through June 30, 2002. The risk option selected by VSHP d/b/a BlueCare defines the allowable administrative fees. These administrative fees equal the administrative fee paid to BCBST by BlueCare.

Beginning July 1, 2002, the stabilization period, the Blue Care line of business received a monthly fixed administrative fee as described in section 2-9.e.1. of the Contractor Risk Agreement. This fixed administrative fee equals the administrative fee paid to BCBST by BlueCare.

4. Claims Payable

As part of the NAIC Annual Statement filing requirements, each MCO is required to provide a statement of actuarial opinion. This statement expresses an opinion on whether the claims payable reported by the MCO is adequate to cover all future obligations. This statement must be prepared by a member of the American Academy of Actuaries. VSHP's statement was prepared by its actuarial department and met all the requirements established by the NAIC. The actuarial statement supported a claims payable amount of $1,556,385. This amount agreed with the amount reported on the NAIC balance sheet as "Claims Unpaid."

It should be noted that the claims payable amount discussed above relates only to the BlueCare plan for medical services performed prior to July 1, 2002. Pursuant to statutory accounting principles, an accrual for claims unpaid is not to be booked for BlueCare after June 30, 2002 or for TennCare Select since they were operating as administrative service organizations (not at risk for medical services). Refer to VI.C.

VSHP uses a combination of the percentage of completion method and a per member per month (pmpm) charge to estimate claim expense that has been incurred but not reported (IBNR). The percentage of completion method is more heavily weighted in the later months. Analysis of payments from January 1, 2002, through May 30, 2003, for medical services with dates of service before January 1, 2003, indicated these payments did not exceed reported claims payable at December 31, 2002, therefore, the reported December 31, 2002 claims payable was adequate as of May 30, 2003.

B. Risk Banding Options

The Contractor Risk Agreement before stabilization offered risk banding options for which the MCO can elect to share income/losses with the State of Tennessee. On July 1, 2001, for the BlueCare line of business, VSHP selected the risk banding option 3 as described in section 3-10.e.2. of the Contractor Risk Agreement whereby VSHP's financial losses under the TennCare Program were limited to $33 million.

Prior to December 31, 2002, the TennCare Bureau made payments to VSHP under the provisions of the risk banding option totaling $11,849,209 for excess losses. These payments were based in part on estimates for claims incurred but not reported. At December 31, 2002, VSHP reduced its estimates for IBNR and correctly recorded a liability of $6,461,647 for amounts due to the TennCare Bureau as a result of overpayments under the risk banding option. As claims payable is more clearly defined with additional claim payments, VSHP is adjusting the remaining liability. In addition, a portion of the liability has been remitted to the TennCare Bureau. As of June 30, 2003, the liability had been reduced to $3,522,702 through adjustments to IBNR and refunds to the TennCare Bureau.

C. Administrative Services Only (ASO)

As previously mentioned, VHSP has operated the TennCare Select line of business as an ASO product since its inception in July 2001. The Contractor Risk Agreement was amended to temporarily operate under a non-risk agreement effective July 1, 2002, so that the BlueCare line of business will also operate as an ASO until December 31, 2003.

Under the NAIC guidelines for ASO lines of business, the financial statements for an ASO exclude all income and expenses related to claims, losses, premiums, and other amounts received or paid on behalf of the uninsured ASO. In addition, administrative fees and revenue are deducted from general administrative expenses. Further, ASO lines of business have no liability for future claim payments; thus, no provisions for IBNR are reflected in the balance sheet for TennCare Select for the entire year and BlueCare for dates of service after July 1, 2002.

VSHP's administration agreement with BCBST stipulates that BCBST will provide administrative services in exchange for the administrative fee paid to VSHP by TennCare. Therefore, on the NAIC statement of Revenue and Expenses, TennCare Select reported $0 net income/loss for the period January 1, 2002, through December 31, 2002; and BlueCare reported $0 net income/loss for the period July 1, 2002, through December 31, 2002.

It should be noted a deviation from ASO guidelines exists, per the Contractor Risk Agreement and Administrative Service Agreement. The required submission of the TennCare Operating Statement should include quarterly and year-to-date revenues earned and expenses incurred as a result of the contractor's participation in the State of Tennessee's TennCare program as if VSHP were still operating at risk. As stated in section 2-10.i. of the Contractor Risk Agreement, VSHP is to provide "an income statement addressing the TennCare operations." Section 2-10.9 of the Administrative Service Agreement requires that VSHP's annual statement "contain a supplemental income statement for TennCare Select detailing the CONTRACTOR's fourth quarter and year-to-date revenues earned and expenses paid as a result of the CONTRACTOR's administration of TennCare Select." VSHP provided this information on the Report 2A.

For the year ended December 31, 2002, VSHP reported $587,599,930 in premiums, $526, 808,622 in medical expenses, and administrative expenses of $60,791,308 for a net income of $0 for the TennCare Select line of business. For the six-month period ended December 31, 2002, VSHP reported $331,059,594 in premiums, $306,468,208 in medical expenses, and $24,591,386 in administrative expenses resulting in a net income of $0 for the BlueCare line of business.

ASO lines of business do not report liabilities for future claims payments under NAIC accounting guidelines. Therefore, there is no provision in the balance sheet for IBNR for TennCare Select for the year. BlueCare reported IBNR only for claims with dates of service prior to June 30, 2002.

D. Medical Loss Ratio/Medical Fund Target

Section 3-10.e.1. of the Contractor Risk Agreement requires all TennCare MCOs "to achieve an annual medical loss ratio of no less than 85% of capitation payments received from TENNCARE based on a calendar year as an accountability measure for Fiscal Year 2001 while new accountability measures are being developed. . . .The intent of the 85% medical loss ratio is that 85% of the capitation rate will be spent on covered medical services for eligible TennCare enrollees." The Administrative Services Agreement for TennCare Select contained no such provision.

Per the Medical Loss Ratio ("MLR") reports submitted to the TennCare Bureau, VSHP reported a medical loss ratio in excess of 85% for dates of service through June 30, 2002.

Effective July 1, 2002, the Medical Fund Target (MFT) report replaced the MLR report. Although estimates for incurred but not reported claims for ASO plans are not included in the NAIC financial statements, these estimates are required to be included in the MFT. For TennCare Select beginning November 2002 and BlueCare beginning July 2002, VSHP submitted monthly the MFT which reports actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MFT estimates for incurred but not reported expenses have been reviewed for accuracy.

No discrepancies were noted during the review of documentation supporting the amounts reported on the Medical Loss Ratio and Medical Fund Target reports.

VII. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether VSHP pays claims promptly within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1) , section 2-18. of the Contractor Risk Agreement, and section 2-9.7 of the Administrative Service Agreement. The requirements of the Contractor Risk Agreement and the Administrative Services Agreement are the same as those required by Tenn. Code Ann. § 56-32-226(b)(1). The statute mandates the following prompt pay requirements:

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.
>
> > (A) "Pay" means that the health maintenance organization shall either send the provider cash of cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.

> (B) "Process" means the health maintenance organization must send the provider a written remittance advice or other appropriate written notice evidencing either that the claim had been paid of informing the provider that a claims has been either partially or totally "denied" and specify all known reason for denial. If a claim is partially or totally denied on the basis the provider did not submit any required information of documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation.

TDCI has previously requested data files from all TennCare MCOs containing all claims processed during the months of October 2002, January 2003 and April 2003. Separate files were submitted for medical and pharmacy claim types. Each set of data was tested in its entirety for compliance with the prompt pay requirements of Tenn. Code Ann. Because these tests were performed on all claims processed in October 2002, January 2003 and April 2003, no projections to the population are needed. Listed below are the results of these analyses:

<u>BlueCare Medical Results</u>

	Within 30 days	Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
October 2002	99.29%	99.97%	**Yes**
January 2003	99.08%	99.97%	**Yes**
April 2003	99.60%	99.99%	**Yes**

<u>BlueCare Pharmacy Results</u>

	Within 30 days	Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
October 2002	99.82%	99.95%	**Yes**
January 2003	99.86%	99.97%	**Yes**
April 2003	99.90%	99.96%	**Yes**

TennCare Select Medical Results

	Within 30 days	Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
October 2002	99.28%	99.97%	**Yes**
January 2003	99.55%	99.93%	**Yes**
April 2003	99.08%	99.98%	**Yes**

TennCare Select Pharmacy Results

	Within 30 days	Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
October 2002	99.99%	100%	**Yes**
January 2003	100%	100%	**Yes**
April 2003	99.90%	99.99%	**Yes**

VSHP was in compliance with Tenn. Code Ann. § 56-32-226(b) for claims processing requirements in the months of October 2002, January 2003 and April 2003 for both the BlueCare and TennCare Select lines of business.

B. Determination of the Extent of Test Work of the Claims Processing System

Several factors were considered in the determination of the extent of test work to be performed in testing VSHP's claims processing system.

The following items were reviewed to determine the risk that VSHP had not properly processed claims:

- Prior examination findings related to claims processing
- Complaints on file with TDCI related to accurate claims processing
- Results of prompt pay testing by TDCI
- Results reported on the claims payment accuracy report submitted to TDCI
- Review of the preparation of the claims processing accuracy report
- Review of internal controls (including the testing of those controls by VSHP)

No significant weaknesses were noted in these reviews; thus, risk was determined to be low.

The review of the claims processing accuracy report included an interview with internal control staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy report. These interviews were followed by a review of the supporting documentation used to prepare the fourth quarter claims payment accuracy report. This review included verification that the number of claims reviewed constituted an adequate sample to represent the population. In addition, claims were selected at random from the source documentation. These claims were reviewed to determine if the information on the supporting documentation was correct. The supporting documents were tested for mathematical accuracy. The amounts from the supporting documentation traced directly to the actual report filed with TennCare. The results of this review of the claims accuracy testing by VSHP indicates procedures and sampling methods adequately reflect payment accuracy percentages. Therefore, substantive claims testing was not expanded by TDCI and State Audit.

C. Claims Payment Accuracy Reporting

Section 2-9. of the Contractor Risk Agreement and section 2-9.1 of the Administrative Services Agreement require that 97% of claims are paid accurately upon initial submission.

VSHP reported the following results for the fourth quarter:

BlueCare

	# of claims tested	Results Reported	Compliance
October 2002	1004	99.6%	**Yes**
January 2003	993	98.5%	**Yes**
April 2003	456	98.5%	**Yes**

TennCare Select

	# of claims tested	Results Reported	Compliance
October 2002	937	99.3%	**Yes**
January 2003	1008	99.8%	**Yes**
April 2003	484	99.3%	**Yes**

VSHP has complied with this provision of the contract.

D. Claims Selected For Testing

Based on results from the review of internal controls, 10 claims from each line of business were selected for testing. VSHP provided data files of paid and denied claims for the months of June 2002 and September 2002. For each claim processed, the data file included the date received, date paid, the amount paid and, if applicable, an explanation for denial of payment. From each data file, 5 claims for each line of business were randomly selected.

To ensure that all claims in the data file included all claims processed in the month selected for testing, the total amount paid per each of the data files was reconciled to the triangle lags and to the general ledger for the respective accounting periods to within an acceptable level.

E. Comparison of Actual Claim with System Claim Data

The purpose of this test is to ensure that the information submitted on the claim was entered correctly in VSHP's claims processing system. Original hard copy claims were requested for the 20 claims tested.

The required data elements of Attachment XII Exhibit A of the Contractor Risk Agreement and the Administrative Services Agreement reported on the BlueCare and TennCare Select claims tested were compared to the data elements entered into VSHP's claims processing system. No discrepancies were noted between the information printed on the tested claims and the data recorded in VSHP's system.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected. All the 10 BlueCare claims and all 10 TennCare Select claims were properly processed as paid, denied or rejected.

G. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts are calculated correctly.

- Of the 10 BlueCare claims tested, all 10 were paid in accordance with the contracted rates.

- Of the 10 TennCare Select claims tested, one claim was incorrectly priced. The claim was manually entered into the system. The incorrect price was the result of human error versus a system processing error. (Control #6)

H. Withhold, Deductible and Coinsurance Testing

1. The purpose of "withhold testing" is to determine whether amounts withheld from provider payments are in accordance with the provider contracts and are accurately calculated. VSHP's contracts with providers do not apply withhold to provider payments.

2. The purpose of testing deductibles and coinsurance is to determine whether enrollees are subject to out-of-pocket payments for certain procedures, whether out-of-pocket payment limits have not been exceeded, and whether out-of-pocket payments are accurately calculated in accordance with section 2-3.i. of the Contractor Risk Agreement and section 2-4.10 of the Administrative Services Agreement.

   All 20 claims tested were subject to deductibles and copayments, and were tested for proper application of deductibles and copayments.

   - For all 10 BlueCare claims, deductibles and copayments were properly applied.

   - An incorrect application of copayment was discovered on one of the 10 TennCare Select claims tested. Based on information concerning the enrollee's eligibility, the enrollee was classified as "Disabled Medicaid" and was not subject to copayments. The examiners noted that the copayment equaled the allowable amount of the claim. The claim was manually entered into the system. The recording of the allowable amount to deductible field rather than to the allowable field was the result of human error versus a system processing error. (Control #6)

   - The accumulation of the enrollees' out-of-pocket costs was computed accurately for all BlueCare and TennCare Select claims tested. None of the enrollees selected exceeded the out-of-pocket limits.

I. Explanation of Benefits ("EOB") Testing

The purpose of EOB testing is to determine whether uninsured and uninsurable members (non-Medicaid) who are subject to deductible and coinsurance are provided

an explanation of benefits in accordance with usual and customary health care industry practices.

The examiners requested EOBs for the 20 claims tested. All 10 BlueCare EOBs requested were provided. All 10 TennCare Select EOBs requested were provided. There were no discrepancies between the information recorded in the claims processing system and the information reported on the EOB.

J. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to the providers accurately reflect the processed claim information in the system.

The examiners requested remittance advices for the 10 BlueCare and 10 TennCare Select claims to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers. No differences were noted between the claims payment per the claims processing system and the information communicated to the providers.

K. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks is to (1) verify the actual payment of claims by VSHP, and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The examiners requested cancelled checks for the 10 BlueCare and 10 TennCare Select claims tested. All 20 cancelled checks were provided by VSHP. These checks cleared the bank within 7 days of issuance by VSHP.

L. Suspended/Unprocessed Claims Testing

The purpose of testing suspended claims is to determine the existence of claims that have been suspended or pended by VSHP, the reasons for suspending the claims, the number of suspended claims that are over 60 days old, and whether a potential material unrecorded liability exists. VSHP provided the examiners a HCFA and UB pended claims report as of May 15, 2003. VSHP reported a total of 2,555 pended BlueCare claims of which 58 were over 60 days old. VSHP reported a total of 3,736 pended TennCare Select claims of which 640 were over 60 days old

The small number of claims on the pend report suggests that VSHP did not have a material unrecorded liability as a result of suspended/unprocessed claims as of the end of fieldwork.

M. Electronic Claims Capability

Section 2-9.g. of the Contractor Risk Agreement states, "The CONTRACTOR shall have in place, an automated claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment …." Section 2-2.h. of the Contractor Risk Agreement requires MCOs to move to electronic billing. Sections 2-1(i) and 2-9.7(b) of the Administrative Services Agreement impose these requirements on TennCare Select. The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II ("HIPAA") requires that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until October 15, 2003, for health plans requesting additional time. Failure to comply with the standards defined for the transactions listed can result in the assessment of substantial penalties.

VSHP has implemented the necessary changes to process claims per the standards outlined in the HIPAA statutes. At the time of fieldwork, VSHP was processing claims under these standards for some of its providers.

N. Weaknesses in Mail Room Controls – Prior Examination Finding

The prior examination by TDCI reported a weakness in the mailroom controls. A review of procedures in place as of March 11, 2002, indicated that VSHP has corrected the weakness. Claims are identified and coded promptly after they are received in the mailroom.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Complaints and Appeals

No deficiencies were noted in the review of provider complaint resolutions. Using VSHP's definition of complaints, five complaints were selected for BlueCare and 5 complaints were selected for TennCare Select from VSHP's complaint log. For all complaints, VSHP was able to provide documentation that the provider had been notified of VSHP's decision regarding the complaint and of the ultimate disposition of the complaint.

Five appeals were selected for BlueCare and 5 appeals were selected for TennCare Select from VSHP's appeal log. For all appeals, VSHP supplied documentation that the provider had been notified of VSHP's decision regarding the appeal and of the ultimate disposition of the appeal. VSHP responded to all appeals tested in a timely manner.

B. Provider Manual

The provider manual outlines written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim. No deficiencies were noted in the review of VSHP's Policy and Procedure Manual.

C. Provider Agreements

Three provider contracts were selected to determine if they contained all the language required by section 2-18. of the Contractor Risk Agreement and of the Administrative Services Agreement. No discrepancies were noted.

A review of selected provider contracts on file with TDCI revealed that VSHP's provider contracts had been approved.

D. Subcontractors and Provider Agreements

1. Compliance with Contractor Risk Agreement and Administrative Services Agreement

During the examination period, VSHP had subcontracts in place with the following companies: Doral, PCS, and Script Pharmacy Solutions, Inc. (d/b/a/ MIM). As discussed previously, both Doral and PCS processed claims. MIM operated as VSHP's pharmacy benefits manager (PBM). VSHP terminated the Doral contract during the examination period when the TennCare Bureau assumed responsibility for dental services.

A review of the PCS and MIM subcontracts revealed that the MIM contract did not contain the required language related to Title VI compliance. The contract with MIM and PCS terminated effective July 1, 2003. At that time, the TennCare Bureau assumed responsibility for pharmacy services.

2. Compliance with Provider Agreement

Examiners tested capitation payments to providers between January 2002 and December 2002 to determine if VSHP had complied with the payment provisions set forth in its provider agreements.

All capitation payments during 2002 were made timely in accordance with the approved provider agreements.

E. Title VI Compliance Testing

Effective July 1996, section 2-24. of the Contractor Risk Agreement and section 2-24 of the Administrative Service Agreement require VSHP to demonstrate compliance with Federal Title VI of the 1964 Civil Rights Act that prohibits discrimination based on race, color or national origin. Based on discussions with various VSHP staff and a review of policies and related supporting documentation, VSHP was in compliance with reporting requirement of section 2-24. of the Contractor Risk Agreement and section 2-24 of the Administrative Services Agreement.

F. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., title 56, Chapter 11, Part 2 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-205 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer or health maintenance organization subject to registration requirements and standards adopted by statue or regulation in the jurisdiction of its domicile which are substantially similar to those